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IN THE

Supreme Court of the United States

Arthur P. Christie, Anthony L. Alford, Daniel A. Deighton, Frederick W. Jennart, David N. Harvey, M.D., Michael A. Hellwege, M.D., F. Hunt Sanders, M.D., Richard J. Sullivan, M.D., Titus A. Taube, M.D., C. Scott Edenfield, M.D., Rahil Kazi, M.D., Richard L. Heaton, M.D., Britton L. Pilcher, M.D., Santanu Das, M.D., Thomas C. Johnson, M.D., Richard B. Ellis, M.D., and Hospital Authority of Houston County d/b/a Houston Medical Center, PETITIONERS

v.

Russell E. Adkins, M.D.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

REPLY BRIEF

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REPLY BRIEF OF PETITIONERS

Respondent concedes that every state has recognized a medical peer review privilege. He also concedes that "admittedly, it is important to the quality of health care to keep peer review documentation and discussions confidential." Opp. at 19. Moreover, Respondent has no persuasive response to the inconsistencies between the Eleventh Circuit's analysis and this Court's decision in *Jaffee*, the tension between this Court's decisions in *University of Pennsylvania* and *Jaffee*, and the conflict between the Eleventh Circuit's decision and the Fifth Circuit's decision in *Harris Methodist Ft. Worth* concerning recognition of a medical peer review privilege.

Instead, Respondent sets up, and then knocks down, two straw men that are not actually implicated by this case. First, Respondent suggests that courts must choose between protecting medical peer review proceedings or allowing federal civil rights claims. That is not the case. Under the state law medical peer review privilege rules, discrimination plaintiffs continue to have access to a wide range of evidence, including depositions and requests for documentary evidence. The medical peer review privilege only shields one narrow category of evidence the disclosure of which would have important institutional ramifications for the overall quality of the health care system.

Second, Respondent suggests that because certain federal and state laws have declined to grant doctors *immunity* from lawsuits alleging discrimination, it follows that there can be no *privilege*

for medical peer review proceedings. Respondent is confusing two different concepts. Congress, in the Health Care Quality Improvement Act ("HCQIA"), along with certain states, has concluded that doctors should not be absolutely immunized from damages claims simply by virtue of the fact that they participate in peer review. But that does not speak to the evidentiary question of whether the records of peer review proceedings should be privileged because their disclosure would undermine the health care system. Congress simply did not speak to that question in the HCQIA, and states have overwhelmingly concluded that the importance of medical peer review to the health care system far outweighs the limited evidentiary value of this particular form of evidence. The Eleventh Circuit's decision severely undermines the judgment of states across the country.

1. As Respondent acknowledges, Opp. at 17, and as shown by the universal recognition of the medical peer review privilege by the states, the medical peer review privilege is critical to the quality of health care provided to the citizens of this country.

Medical peer review proceedings provide one of the few ways by which hospitals can discover and report doctors who pose a threat to their patients. However, the effectiveness of peer review proceedings depends upon the willingness of the participants to engage in candid discussions of the shortcomings of the treating physicians – physicians who often are colleagues of those participating in the review. Am. Hosp. Ass'n Br. at 4-5; Joint Comm'n Br. at 2.

As recognized by the states, the candor

necessary for effective peer review will suffer in the absence of a privilege. *See, e.g., Cruger v. Love*, 599 So. 2d 111, 114-15 (Fla. 1992) ("privilege afforded to peer review committees is intended to prohibit the chilling effect of the potential public disclosure of statements made to or information prepared for and used by the committee in carrying out its peer review function"). Indeed, medical peer review presents an even more compelling case for a privilege than does the psychotherapist-patient privilege protected in *Jaffee*, because the physicians who participate in a peer review are not acting in their self-interest. In the absence of a privilege, a patient still has a powerful incentive to provide sensitive information to her therapist: she will not receive effective psychotherapy without it. The physician who sits in judgment of his fellow doctor has no such self-interest, because the benefits of peer review flow entirely to others, *i.e.*, future patients and the public generally.

Like the psychotherapist-patient privilege recognized in *Jaffee*, the medical peer review privilege is "rooted in the imperative need for confidence and trust," promotes important "public ends," is recognized by every state in the country, and should be recognized under Federal Rule of Evidence 501. See *Jaffee v. Redmond*, 518 U.S. 1, 10, 13 (1996). The Eleventh Circuit's refusal to recognize the medical peer review privilege is contrary to *Jaffee* and should be reversed. It also is contrary to the reasoned judgment of every state that the importance of protecting the confidentiality of medical peer review communications necessitates recognition of a medical peer review privilege. *See, e.g., Sun Health Corp. v. Myers*, 70 P.3d 444, 447 (Ariz. Ct. App. 2003) ("The confidentiality of

peer review committee proceedings is essential to achieve complete investigation and review of medical care. Because review by one's peers within a hospital is not only time consuming, unpaid work, [and] likely to generate bad feelings and result in unpopularity, it is imperative to preserve the peer review privilege.") (internal citations and quotations omitted).

2. Respondent also offers no persuasive response to the tension between this Court's decisions in *University of Pennsylvania* and *Jaffee*. Contrary to Respondent's suggestion, *University of Pennsylvania* did not establish a bright line rule that peer review discovery is always allowed if the case in which peer review is sought involves an allegation of discrimination in the peer review process itself. Opp. at 6-7. As shown in Petitioners' petition, Pet. at 28-29, and further addressed below, such a rule is entirely inconsistent with the manner in which the states apply their peer review privilege laws.

The issue in *University of Pennsylvania* was "whether a *university* enjoys a special privilege, grounded in either the common law or the First Amendment, against disclosure of peer review materials that are relevant to charges of racial or sexual discrimination in *tenure decisions*." 493 U.S. 182, 184 (1990) (emphasis added). The medical peer review privilege is distinguishable from a peer review privilege in the academic context because a medical peer review privilege is recognized by every state and "is sine qua non of adequate hospital care." *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94, 103 (5th Cir. 1992).

Respondent simply ignores the tension between *University of Pennsylvania* and *Jaffee*. Specifically, while *University of Pennsylvania* suggests a balancing test weighing the value of confidentiality against the need for disclosure in a particular case to determine whether to recognize a privilege, *Jaffee* expressly rejects such a balancing test. *Compare University of Pennsylvania*, 493 U.S. at 193 *with Jaffee*, 518 U.S. at 17. As *Jaffee* explained, such a balancing test eviscerates the effectiveness of a privilege: "[I]f the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all." 493 U.S. at 18 (internal quotations and citation omitted). And it is this tension between the *University of Pennsylvania* and *Jaffee* which has led to inconsistent results in the lower courts concerning recognition of the medical peer review privilege. Pet. at 24-25.

Moreover, Respondent ignores the fact that while the Fifth Circuit in *Harris Methodist Ft. Worth* declined to "define the scope" of any medical peer review privilege, it did, in fact, engage in the same comparison conducted by the Eleventh Circuit—the importance of rooting out discrimination against the importance of protecting medical peer review proceedings—and reached an entirely different result. *Compare Adkins v. Christie*, 488 F.3d 1324, 1328-29 (11th Cir. 2007) ("the privilege must be considered against a corresponding and overriding goal – the discovery of evidence essential in determining whether

there has been discrimination in employment") with *Harris Methodist Ft. Worth*, 970 F.2d at 103 ("important public interest" in the confidentiality of medical peer review is "overrid[ing]" goal supporting existence of privilege). *Harris Methodist Ft. Worth*, therefore, demonstrates a "conflict in approach" at least as strong as the split that prompted the Court to grant review in *University of Pennsylvania*.

3. Respondent suggests that courts must choose between protecting medical peer review proceedings or allowing federal civil rights claims. Opp. at 4. That is not the case.

Indeed, Respondent does not even address the numerous mechanisms outlined in Petitioners' petition as to how a plaintiff-physician could prove a discrimination claim, provided a viable one exists, without the confidential peer review materials. Pet. at 19. Along with the depositions outlined in Petitioners' petition, a physician-plaintiff also could seek similar documents from parties and non-parties. To be clear, the medical peer review privilege only shields one narrow category of evidence and that narrow category has important institutional ramifications for the overall quality of the health care system. *See, e.g., Patton v. St. Francis Hosp.*, 534 S.E.2d 526, 530 (Ga. App. 2000) (medical peer review privilege applies in suit challenging peer review process itself and privilege does "not deprive [plaintiff] of his right to access to the courts; [it] merely withhold[s] from him a certain type of evidence which would otherwise be available to him"); *Sun Health Corp.*, 70 P.3d at 449 ("A plaintiff has reasonable alternative ways to obtain the information without seeking privileged [peer review] information.").

4. Respondent, joined by amicus the Association of Black Physicians,[1] contends that because the HCQIA failed to grant doctors immunity from lawsuits alleging discrimination, that somehow Congress has declared that a peer review privilege should not be recognized. Opp. at 15; Ass'n of Black Physicians' Br. at 10. The HCQIA's text and legislative history shows this assertion is incorrect.

Congress simply did not speak to the question of recognition of a medical peer review privilege in the HCQIA. Specifically, in enacting the HCQIA, Congress was responding to concerns that "[t]he threat of private money damage liability under Federal laws, including treble damages under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." 42 U.S.C. § 11101(4). Encouraging participation in peer review was important, Congress found, because of a "national need to restrict the ability of incompetent physicians to move from [s]tate to [s]tate without disclosure or discovery of the physician's previous damaging or incompetent performance." 42 U.S.C. § 11101(2). The Act, to encourage participation in effective medial peer review, assuages participants' concerns over liability by providing those involved in peer review with qualified civil immunity. See 42 U.S.C. § 11111.

Far from disapproving of an evidentiary privilege, Congress' enactment of the HCQIA complemented the peer review privilege. Congress' intent was for the HCQIA *not* to affect the states'

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[1] Petitioners consented to the Association of Black Physicians' request to file an amicus brief.

universal recognition of the privilege and corresponding application of the privilege in federal courts under Rule 501. Congressman Waxman, the main sponsor of the House bill, stated:

> The basic point to be made is that the courts should not read anything in this bill as authorizing the overriding of any State *and Federal law* relating to discovery. Specifically, I understand that there are a number of State shield laws that restrict the type of evidence that may be introduced in lawsuits challenging a disciplinary action in the context of peer review. Nothing in this bill is intended to preempt or override any such State shield law.

132 Cong. Rec. H11588-02 (emphasis added).

Yet that is what Respondent is arguing here, asserting the HCQIA, a statute that deals with immunity from damages, bars recognition of the evidentiary privilege under Rule 501. Respondent's argument was specifically rejected by the Fourth Circuit in *Virmani v. Novant Health Inc.*, a case upon which Respondent principally relies. 259 F.3d 284, 291 (4th Cir. 2001) ("we cannot conclude that Congress actually considered and rejected a privilege for medical review materials when enacting the HCQIA") (emphasis added). Moreover, in *Harris Methodist Ft. Worth*, the Fifth Circuit cited the HCQIA as, in fact, supporting recognition of the privilege. 970 F.2d at 103 ("As Congress has recognized, peer review materials are sensitive and inherently confidential, and protecting that confidentiality serves an important public interest. 42 U.S.C. §§ 11101(5), 11137(b)."). The Fifth Circuit's

analysis is consistent with the HCQIA's text and history, which demonstrate that the Act supports recognition of a medical peer review privilege under Rule 501.

Respondent also is wrong with respect to most of the states he contends have a malice/bad faith exception to a *privilege* from discovery of confidential, medical peer review communications. *See California Eye Institute v. Superior Court*, 215 Cal App 3d 1477 (Cal. App. 5th Dist. 1989) (providing "narrow exception" to peer review privilege for administrative mandamus actions and not for damages actions); *Freeman v. Piedmont Hosp.*, 444 S.E.2d 796, 798 (Ga. 1994) (no bad/faith malice exception for peer review discovery privilege); La. Rev. Stat. Ann. § 40:2205 (malice exception exists for immunity from liability, but not for *privilege* from discovery) Mich. Comp. Laws §§ 333.20175(8), 333.21515 (medical peer review discovery privilege); N.J. Stat. Ann. § 2A:84-22.8 (medical peer review discovery privilege); *Daly v. Genovese*, 466 N.Y.S.2d 428, 430 (App. Div., 2nd Dep't 1983) ("the allegation that the statements were made with malice, while relevant to a determination of whether they are privileged with respect to *liability*, is wholly irrelevant to the question of whether they are privileged from *discovery* under the terms of the statute"); Okla. Stat. tit. 63, § 1-1709 (medical peer review discovery privilege); Pa. Stat. Ann. tit. 63, § 425.4 (medical peer review discovery privilege); Tenn. Code Ann. § 63-6-219(e) (medical peer review discovery privilege).

As for the other states referred to by Respondent, they either allow limited peer review discovery but then impose absolute immunity from

liability to members of a peer review committee, Md. Code Ann. Health Occ. §§ 1-401(e), (f); allow peer review discovery when the peer review process itself is being challenged, Mo. Rev. Stat. § 537.035(5); or allow peer review discovery only if, after an *in camera* review, a trial judge makes a finding that the documents are relevant to an antitrust or civil rights claim, see *In re Ching*, 32 S.W.2d 306, 313 (Tex. Ct. App. 2000). Notably, *Jaffee* indicates that limited variations in the scope of the protections afforded by a privilege do not alter the "[s]tates' unanimous judgment that some form of [the] privilege is appropriate." 518 U.S. at 14 n.13.

Significantly, Georgia's appellate courts have specifically rejected the contentions made by Respondent here – that the medical peer review privilege should apply because the peer review process itself is at issue and because allegations of discrimination are involved. In fact, the Georgia Supreme Court explicitly held that interpreting Georgia's peer review privilege to include a malice/bad faith exception would:

> open the door of discovery too widely by stripping the entire peer review process of its confidentiality. . . . . Allowing an allegation of malice to trigger the applicability of [an] exception to the confidentiality requirement would result in the opportunity for full discovery of peer review material in every such case. The use of a bare allegation of malice is not sufficient to elevate a plaintiff's access to evidence over this court's previously stated preference for preserving the candor necessary for effective

peer review.

Freeman, 444 S.E.2d at 798 (emphasis added).

Similarly, the Georgia Court of Appeals has expressly rejected the argument that Georgia's peer review statute does not apply in cases challenging the peer review process itself: "To allow [such an] exception . . . would undermine the confidentiality afforded medical review committees and would swallow the rule. It is a rare case indeed in which disciplined physicians do not challenge the peer review process." *Patton*, 539 S.E.2d at 529-30 (internal citations omitted).

These opinions establish that, had Respondent filed this suit in state court, he would not be entitled to the peer review documents he seeks. Respondent's position, as accepted by the Eleventh Circuit, boils down to creating a rule that allows a plaintiff unfettered access to confidential peer review materials simply by baldy asserting discrimination or another federal claim.[2] While Respondent suggests Petitioners "miss the point" because physicians participating on peer review committees "have nothing to worry about"

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[2] In recognizing the medical peer review, the district court (1) conducted its own in camera reviews of the actual peer review documents, (R3-74-1; R3-80-2; R5-102-1; R7-169-1; R7-175-1); (2) asked repeatedly for Respondent to proffer any information he had to support his claims, which Respondent was unable to do, (R3-80-1-2; R5-103-12; R5-109-6; R7-169-1); (3) required the parties to submit discovery plans, which Respondent refused, (R1-82-2; R3-87-1; R4-96-1; R3-89-4); and (4) detailed for Respondent the manner in which he could prove his claims, but which Respondent elected not to pursue, (Pet. App. 20a).

if they "do not act with discriminatory animus in peer review proceedings,"[3] Opp. at 20, the Eleventh Circuit's rule means that all a plaintiff needs to do is allege discrimination to entirely eviscerate the privilege. Allowing a plaintiff unfettered access to each and every peer review file at a hospital simply by baldly asserting a discrimination claim invites the filing of meritless litigation against hospitals in the hope of coercing settlement, promotes forum shopping, abrogates each states' recognition of the medical peer review privilege, and puts at risk thousands of individual patients who rely each year on hospitals and their medical staffs for life-saving treatment and care.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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[3] Respondent has never made any showing of any discrimination perpetrated by any Petitioner. As Petitioners noted in their petition, the district court repeatedly warned Respondent throughout this action his Complaint appeared to be nothing more than a "fishing expedition." *Cf. Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955, 1967 (2007).

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